

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Julia Ribaldo Extended Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 Golf Park Drive Lake Ariel, PA 18436	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, resident council meeting minutes, and resident and staff interviews, it was determined the facility failed to provide an environment that promotes each resident's quality of life by ensuring residents' personal space was free from intrusions by other residents (Residents 16 and 19), including experiences reported by two residents out of the 25 residents sampled (Residents 3 and 29) and experiences reported by six out of the eight residents during a resident group interview (Residents 26, 28, 32, 49, 69, and 90). Findings include: A review of resident council meeting minutes dated May 27, 2025, revealed residents in attendance had concerns regarding one resident wandering into resident rooms. A review of the meeting minutes failed to determine if this concern was resolved. A review of resident council meeting minutes dated June 26, 2025, revealed residents in attendance had concerns regarding wandering residents. The minutes indicated the concerns for wandering residents were better. A review of the meeting minutes failed to determine if this concern was resolved. A review of resident council meeting minutes dated July 29, 2025, revealed residents in attendance had concerns regarding wandering residents. The meeting minutes indicated the issue of wandering residents is better; however, it was indicated that one resident continues to wander through resident room doorways. Further review of the meeting minutes failed to determine if this concern was resolved or if any further actions were taken to resolve the issue. A clinical record review revealed Resident 3 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of an admission Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 13, 2025, revealed that Resident 3 was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review revealed Resident 29 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of a quarterly Minimum Data Set assessment (MDS) dated [DATE], revealed that Resident 29 was moderately cognitively impaired with a BIMS score of 12 a score of 08-12 indicates cognition is moderately impaired. A clinical record review revealed Resident 16 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of a significant change in status Minimum Data Set assessment (MDS) dated [DATE], revealed that Resident 16 is severely cognitively impaired with a BIMS score of 4 a score of 00-07 indicates cognition is severely impaired. A clinical record review revealed Resident 19 was admitted to the facility on [DATE], with diagnoses that included dementia. A review of a significant change in status Minimum Data Set assessment (MDS) dated May 19, 2025, Section C100 Cognitive (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395493
		If continuation sheet Page 1 of 11

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on resident council meeting minutes, resident and staff interviews, and observations it was determined the facility failed to maintain an adequate supply of clean linens to meet the needs of residents for 2 of 4 resident care units observed (E Hallway and A Hallway). Finding include: Review of the Resident Council meeting minutes dated July 29, 2025, revealed residents expressed concerns regarding the availability of linens. The minutes further documented that the Nursing Home Administrator identified nurse aides were discarding washcloths, and the Administrator noted that a lot of linen had been ordered for staff to utilize while providing care to residents. Observations conducted on August 12, 2025, at approximately 11:00 AM in the E Hallway revealed one washcloth available for resident care. Additional observation of the A Hallway at approximately 11:15 AM on the same day revealed a linen cart containing only three bath towels and three washcloths available for resident care. Observations conducted on August 13, 2025, at 8:15 AM in the E Hallway revealed no washcloths and only four bath towels available for resident care. On August 14, 2025, at 10:00 AM, observation of the A Hallway revealed only two bath towels and two washcloths available for resident care. An interview conducted with Employee 10 (Nurse Aide) on August 14, 2025, revealed the staff frequently experienced difficulty finding clean washcloths and towels. The staff member reported that clean linens were not delivered to the floor until after 9:00 AM, despite care being provided prior to that time, resulting in a shortage of available linens. Observation conducted on August 14, 2025, at approximately 11:00 AM of the facility laundry room revealed no additional linens available for staff use. Further observation of the linen closet located outside the E Hallway revealed 12 washcloths and 10 bath towels in storage. An interview with the Nursing Home Administrator on August 14, 2025, at approximately 1:00 PM revealed the facility had previously identified an issue with linens being sent out to be laundered and not returned. The Administrator was unable to provide further information to confirm that the facility maintained an adequate number of linens to meet residents' daily needs. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services. 28 Pa. Code 205.74 Linen.		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on a review of scheduled facility mealtimes, select facility policy, and resident and staff interviews, it was determined that the facility failed to consistently provide snacks as desired by residents, including experiences reported by four out of eight residents during a group interview (Residents 28, 32, 69, and 90). Findings include: A review of the facility policy titled Meal Times and Frequency Policy, last reviewed by the facility on February 1, 2025, revealed that it is the facility policy that there will be no more than 14 hours between a substantial evening meal (dinner) and breakfast the following day; except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal (dinner) and breakfast the following day if a resident group agrees to this meal span. A review of the facility's scheduled mealtimes revealed that the time between dinner and breakfast the next day exceeds 14 hours. Specifically, residents residing in the North Nursing Unit Area 1 are scheduled to receive dinner at 4:40 PM and receive breakfast at 7:10 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 30 minutes. Residents residing in the North Nursing Unit Area 2 are scheduled to receive dinner at 5:00 PM and receive breakfast at 7:20 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 20 minutes. Residents residing in the South Nursing Unit Area 1 are scheduled to receive dinner at 4:50 PM and receive breakfast at 7:15 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 25 minutes. Residents residing in the South Nursing Unit Area 2 are scheduled to receive dinner at 5:15 PM and receive breakfast at 7:30 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 15 minutes. During a resident council interview on August 13, 2025, at 10:00 AM, four out of eight residents (Residents 28, 32, 69, and 90) indicated that a snack is not consistently offered in the evenings. Resident 69 explained that on occasion she is offered a snack, but it does not happen often. Residents 28, 32, and 90 reported not being offered an evening snack. During an interview on August 14, 2025, at approximately 2:00 PM, the Nursing Home Administrator (NHA) provided a list of the rotating available snacks for residents. The NHA was not able to provide documented evidence that snacks were consistently offered to residents in the evening. The NHA confirmed it is the facility's policy to offer residents nourishing snacks in the evening. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, a review of facility-provided documents, and resident and staff interviews, it was determined the facility failed to maintain an effective pest control program on two of two nursing units (South Nursing B Hall and North Nursing D Hall) and in the North Nursing Resident Dining/Lounge area. In addition, two residents out of twenty-five sampled (Residents 62 and 81) and six residents out of eight during a resident group interview (Residents 26, 28, 32, 49, 69, and 90) reported ongoing problems with small black flies, gnats, or ants in resident rooms and common areas. Findings include: A review of a facility policy entitled Pest Control Policy that was last reviewed on February 1, 2025, indicated routine pest control procedures will be in place to prevent pest infiltration and contracted pest services will document all visits along with actions taken. A review of the facility's current contract with the pest management contractor signed and dated August 12, 2019, revealed year-round protection against pests (except for gnats, outdoor pests and other free flying insects such as mosquitos, lawn insects and pests) and an inspection and report with each visit. A review of Resident Council Meeting minutes dated June 26, 2025, and July 29, 2025, indicated that residents reported observations of small black flies/gnats and ants were observed in their rooms and resident common areas. During a resident council interview on August 13, 2025, at 10:00 AM, six out of eight residents (Residents 26, 28, 32, 49, 69, and 90) reported ongoing concerns with gnats, flies, or ants in their rooms or resident common areas throughout the facility. The six residents described seeing multiple flying insects or pests throughout the day. During an interview with Resident 81 on August 12, 2025, at 10:25 AM, small black flies were reported and observed during the interview flying in the resident's room. Resident 81 reported the facility was made aware and a few weeks ago, the bug guy was here to spray for insects but they were still observed. Additionally, the resident pointed out the bug light that was placed on the dresser and reported family bought it to help get rid of the black flies. An observation on August 12, 2025, at 2:15 PM revealed small flying insects in the B nursing hallway. An observation on August 12, 2025, at 2:20 PM revealed several small black flying insects on a white shower chair in the B hallway. An observation in Resident 62's room on August 13, 2025, at 12:15 PM, revealed several small black flies flying around the room and the resident reported the facility was aware. The resident indicated the flies and ants were on-going over the last few months despite the facility being informed. Observation of the North Nursing Unit resident pantry area on August 13, 2025, at 12:30 PM, revealed several small black flies/gnats flying around the garbage can and ice machine. A review of facility-provided pest control invoices revealed the following: Invoice #667 (May 24, 2025): Documented two pesticide treatments but no description of services performed. Invoice #680 (June 26, 2025): Noted drain flies in the kitchen and hallways and indicated need to really clean all restroom floors and check on pipe in kitchen and documented two pesticide treatments. Invoice #700 (July 31, 2025): Documented service to all rooms, restrooms, dining areas, and the kitchen, including baseboard spraying and bait station checks, with two pesticide treatments applied. The facility was unable to provide additional documentation demonstrating consistent pest control follow-up, detailed treatment outcomes, or contractor recommendations for resolving persistent pest issues. During an interview with the Nursing Home Administrator on August 15, 2025, at 10:00 AM, the above findings were reviewed. The Administrator acknowledged that the facility continued to experience pest control issues despite treatments and was considering contracting with a different pest control company. 28 Pa. Code 201.18 (e) (2.1) Management.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and resident interviews, it was determined the facility failed to develop and implement a comprehensive, person-centered care plan that addressed the resident's individualized needs and interventions for safe transfers for one out of 25 residents sampled (Resident 22). Findings include: A clinical record review revealed Resident 22 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function) and anxiety disorder (a condition in which excessive worry causes clinically significant distress or impairment in social, occupational, or other areas of functioning). A physician's order indicated Resident 22 required the assistance of two staff members for transfers using the standing lift (mechanical device used to help a resident who has some weight bearing ability but cannot safely stand or transfer without assistance) initiated on January 14, 2025. A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 23, 2025, revealed that Resident 22 is moderately cognitively impaired with a BIMS score of 08 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 08-12 indicates moderate cognitive impairment). A progress note dated August 11, 2025, at 10:45 PM documented that Resident 22 bit a nurse aide during a transfer to bed performed by two staff members. The note indicated Resident 22 stated, Yes, I bit you, and that the nursing supervisor was informed of the incident. During an interview on August 13, 2025, at 9:30 AM, Resident 22 explained she was upset by the way she was transferred to bed earlier this week. Resident 22 indicated that two staff manually transferred her to bed without the use of the standing lift as normally performed, which frightened her and caused distress. Following inquiries conducted during the survey week, Resident 22's care plan was updated on August 14, 2025, to include that she experienced severe anxiety regarding transfers with the standing lift. The updated intervention specified the standing lift as the primary transfer method; however, staff could use a manual two-person assist, when necessary, due to the resident's anxiety or behavioral responses. During an interview on August 14, 2025, at 9:25 AM, Employee 2, Director of Rehabilitation Services, confirmed that the standing lift with two staff was the ordered method for Resident 22's transfers and that staff were expected to follow physician orders and the individualized plan of care. Employee 2 indicated the care plan was updated on August 14, 2025, after learning of Resident 22's anxiety during transfers. During an interview on August 14, 2025, at 11:35 AM, Employee 3, Nurse Aide (NA), stated that on August 11, 2025, at approximately 9:45 PM, she and Employee 4, NA, manually transferred Resident 22 into bed. Employee 3 indicated Resident 22 became anxious and bit her during the transfer. Employee 3 reported this incident to the therapy department on August 12, 2025. Employee 4, NA, was not available for interview on August 14, 2025. During an interview on August 14, 2025, at approximately 2:00 PM, the above findings were reviewed with the Nursing Home Administrator (NHA) and Director of Nursing (DON). Through this review, it was established that staff are expected to follow physician orders and implement each resident's individualized plan of care. It was further confirmed during the review that Resident 22's plan of care did not identify her anxiety regarding transfers, nor did it include the option for a manual two-person assist until updates were made on August 14, 2025, following surveyor inquiries. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa Code 211.12 (d)(1)(3) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of clinical records, documentation provided by the facility, and resident and staff interviews, it was determined that the facility failed to implement adequate safety measures to prevent accidents for two out of 25 residents sampled (Resident 62 and 63). Findings include: A review of facility policy titled Self-Administration of Medications, last revised June 2024, revealed the interdisciplinary team should assess and determine with respect to each resident whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition. The policy indicates that if it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan, the facility should routinely assess the residents cognitive, physical and visual ability to carry out this responsibility, and the resident should have a locked medication storage compartment in their room so that another resident is not is not able to access the medications. A clinical record review revealed Resident 62 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (a disease that restricts airflow to the lungs and causes breathing problems). A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 19, 2025, revealed that Resident 62 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 13-15 equates to being cognitively intact). A review of the clinical record revealed a document labeled Self-Administration of Medications dated for December 15,2024, indicated the resident did not want to self-administer medications. During an observation on August 12, 2025, at 11:15AM, in Resident 62's room, a bottle of Pepto Bismol (over the counter antacid/antidiarrheal medication) was noted in a basket on the resident's bedside. During an interview with the resident during this observation, the resident stated her nephew usually brings her snacks, and adult briefs and other things she needs. She stated the Pepto Bismol was brought in by her nephew. During an interview on August 13,2025, at 12:00 PM with Resident 62, the resident opened her bedside table drawer, and two inhalers were noted to be inside the drawer: A Trelegy Ellipta inhaler (prescription therapy inhaler for long term maintenance of COPD) with the date of 6-22 written on it, as well as a Combivent inhaler (prescription inhaler for COPD) with no date observed to be on it. During the interview the resident stated that the drawer does not lock, and she keeps them there in the event she becomes short of breath. When asked how the resident obtained the inhalers, she stated, one of the nurses gave them to me. She was unable to recall which nurse provided her the inhalers, nor was she able to recall how long she had them in the bedside table drawer. During this interview, the basket with the bottle of Pepto Bismol was noted to be on the resident's bed.An interview was conducted on August 14, 2025, at approximately 2:00 PM with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) to discuss the above findings related to the facility's failure to maintain the residents' environment free of potential accident hazards by leaving medications accessible to residents at their bedside which allows accidental consumption to other residents. A clinical record review revealed Resident 63 was admitted to the facility on [DATE], with diagnoses that include Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). A review of a quarterly Minimum Data Set assessment (MDS) dated [DATE], revealed that Resident 63 has moderate cognitive impairment with a BIMS score of 10; a score of 08-12 indicates cognition is moderately impaired. A review of Resident 63's care plan revealed he has a problem with noncompliance related to refusal to participate in restorative programs, refusal of medication, and attempts to go behind the front desk and push a button to allow visitors or staff to enter the building, initiated on July 1, 2025. Interventions implemented, including a (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, observations, and staff and resident interviews, it was determined the facility failed to ensure oxygen therapy was administered and maintained in accordance with physician orders and facility policy, including requirements for equipment labeling, dating, and routine maintenance, in a manner that minimized the risk for infection for two residents out of twenty-five sampled (Residents 3 and 62). Findings include: A review of the facility policy titled Oxygen Administration Policy, last reviewed by the facility on February 1, 2025, revealed it is the facility's policy that licensed clinicians with demonstrated competence will administer oxygen by way of the specified route as ordered by a provider. The policy indicates changing the humidifier bottle (containers attached to an oxygen concentrator to add moisture to the oxygen being delivered) when empty; length of use is dependent upon the liter flow setting (a measurement describing the amount of oxygen delivered in liters per minute, abbreviated as L/min). A clinical record review revealed Resident 3 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lungs that blocks airflow and makes it hard to breathe). A physician's order dated July 12, 2025, directed staff to administer oxygen (O₂) via nasal cannula (a thin tube delivering oxygen through the nostrils) continuously at 3 liters per minute (3 L/min), with humidification added for comfort if needed. Staff were further directed to check the oxygen concentrator for proper function, verify oxygen saturation (the amount of oxygen in the blood), and maintain humidification as appropriate. Additional orders instructed staff to clean the oxygen concentrator and filter, wipe down equipment, air-dry the filter, and change tubing weekly (every seven days). An observation on August 12, 2025, at 10:01 AM, revealed Resident 3 was in her bedroom receiving oxygen by way of the nasal cannula. The plastic oxygen humidification bottle was observed sitting directly on the floor (storing medical equipment on the floor creates a risk of contamination because the floor surface cannot be considered a clean or sanitary area for equipment that delivers oxygen directly to a resident) with a clear plastic bag next to it. The humidification bottle and tubing were not dated. The humidification bottle appeared empty. A follow-up observation on August 13, 2025, at approximately 9:30 AM, revealed Resident 3 was in her bedroom receiving oxygen by way of the nasal cannula. The plastic oxygen humidification bottle was attached to the oxygen concentrator. The humidification bottle and tubing were still not dated and empty. An interview conducted with Employee 1, Registered Nurse (RN), at 9:30 AM on August 13, 2025, confirmed the humidification bottle and tubing for Resident 3 were not dated and the bottle was empty. A review of Resident 62's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). A physician's order dated August 12, 2025, directed staff to administer oxygen at 2 L/min via nasal cannula continuously, adding humidification if oxygen exceeded 4 L/min or for comfort if needed. Staff were also instructed to clean the concentrator, change the tubing weekly, and clean the filter. An observation August 12, 2025, at approximately 11:15 AM revealed a clear plastic bag attached to the oxygen concentrator with 7/23 (date) written on it. The bag appeared intended to store the nasal cannula when not in use; however, the nasal cannula and oxygen tubing were observed laying across the length of the bed with the nasal cannula on the floor. The oxygen humidification bottle was observed sitting on the floor with the attachment straps broken, preventing it from being secured to the concentrator. The humidification bottle was not dated. An observation on August 13, 2025, at 12:00 PM revealed the oxygen humidification bottle remained on the floor with the attachment straps still broken, preventing it from being secured to the concentrator. The humidification bottle was not dated. During an interview at 12:07 PM, Employee 11 confirmed the humidification bottle was on the floor, the straps were broken, and the bottle was not dated. During an interview with the Nursing Home Administrator (NHA) on August 14, 2025, at 1:30 PM, the above observations and findings were (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Julia Ribaldo Extended Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 Golf Park Drive Lake Ariel, PA 18436	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed with the NHA and confirmed the humidification bottles should not be stored directly on the ground. The NHA indicated that bags should be placed around the bottles and dated when the bottles were last changed. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and select facility policy review and staff interview, it was determined the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis for one resident out of 25 sampled residents (Resident 19). Findings include: A review of the facility's policy entitled Pain Management with a policy review date of February 1, 2025, indicated that non- pharmacological interventions will be attempted prior to the admission of a PRN (as needed) medication, If the nonpharmacological interventions fail then with corresponding intensity ratings, the resident will be administered the medication ordered for the corresponding pain rating within the PRN order. A clinical record review revealed that Resident 19 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how one feels, thinks, and behaves and can lead to a variety of emotional and physical problems) and unspecified dementia with unspecified severity with agitation (a condition in which a person has memory loss and thinking problems due to brain changes, with the exact type and stage not yet identified. The person also shows signs of restlessness or irritability, such as pacing or difficulty sitting still.). A review of Resident 19's admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 19, 2025, revealed that Resident 19 was severely cognitively impaired with no BIMS score (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 99 or no BIMS score indicates the resident was unable to complete the interview). A review of Resident 19's clinical record revealed a physician's order dated April 11, 2024, for Acetaminophen 325 mg, chewable tablet, give 2 tablets by mouth every four hours as needed (PRN) for pain scale of 1-3 (pain scale where 1 is the least amount of pain and 10 is the worst amount), not to exceed 3 grams in 24 hours. Further review of Resident 19's clinical record revealed a physician's order dated April 25, 2025, for Acetaminophen 650 mg tablet, extended release, administer twice daily at 9:00 AM and 9:00 PM for pain management not to exceed 3000 mg in 24 hours. The physician's order did not identify a level of pain (such as mild, moderate or severe or a pain scale of 0-10 (a scale to evaluate pain where 0 is no pain and 10 is severe pain) Continued review of Resident 19's clinical record revealed a physician's order dated July 26, 2025, for Morphine Sulfate oral solution (opioid pain medication) 100 mg/5 ml, (20 mg/ml), amount to administer 0.25 ml. PRN for pain/SOB (shortness of breath).The physician's order did not indicate a level of pain (such as mild, moderate or severe or a pain scale of 0-10.) making it difficult for staff to determine which medication to administer as both medications are used for different pain level intensity as stated in the facility policy. A review the resident's electronic Medication Administration Record (eMAR is used to document medications taken by each resident) dated August, 2025, revealed that the PRN Morphine Sulphate solution (opioid pain medication) was administered without any documented attempts of nonpharmacological interventions and without assessing Resident 19 for a pain level to determine if a non-opioid medication would be appropriate on the following dates as follows:August 12, 2025, at 7:43 PM, administered PRN opioid pain medication without assessing Resident 19 for a pain level to determine if a non-opioid medication would be appropriate and without attempted nonpharmacological interventions. August 14, 2025, at 4:10 AM, administered PRN opioid pain medication without assessing Resident 19 for a pain level to determine if a non-opioid medication would be appropriate and without attempted nonpharmacological interventions. An interview was conducted with the NHA (Nursing Home Administrator) on August 15, 2025, at 9:30 AM, to review the above findings related to the facility failure to assure that licensed nursing staff attempted non-pharmacological interventions prior to administering analgesic pain medication that included opioids. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.		